

SPECIMEN

RELIANCE STANDARD

Life Insurance Company

Home Office: Chicago, Illinois • Administrative Office: Philadelphia, Pennsylvania

INSURED: **City of Durham**
(Herein called the Policyholder)

POLICY NUMBER: **SLM540087**

EFFECTIVE DATE: **September 1, 2013**

STATE OF ISSUE: **North Carolina**

Throughout this Policy, "you" and "your" refer to the Policyholder/Participating Unit.

Reliance Standard Life Insurance Company is referred to as "we", "our", "us" or "the Company" in this Policy.

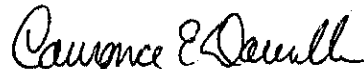
We will pay you when you have a claim and provide other rights and privileges, subject to all the terms and conditions of this Policy. This Policy is issued in consideration of the Policyholder's application, your application and your payment of premiums.

This Policy is delivered in the State of Issue, and is governed by the laws of that state. Your Participation Agreement and Request for Excess Loss Indemnity Coverage, along with a copy of your Employee Benefit Plan document, are part of this Policy.

This Policy is signed for us by:



Secretary



President

EXCESS LOSS INDEMNITY GROUP POLICY

SCHEDULE OF INSURANCE

Policyholder/Participating Unit: **City of Durham**
Address of Policyholder/Participating Unit: **101 City Hall Plaza, Durham, NC 27701**
Policyholder's/Participating Unit's Policy Number: **SLM540087**

Policyholder's/Participating Unit's

Policy Period: From: **09-01-2013** To: **8-31-2014**
Inception Date Expiration Date
(12:01 AM Standard Time at the Participating Unit's Address)

Legal name and address of any subsidiaries or affiliated companies (companies under common control through stock ownership, contract or otherwise) to be covered. **N/A**

Policyholder's/Participating Unit's Appointed Plan Supervisor: **BC/BS of North Carolina**

Disabled Lives:	Covered	(X)	Not Covered	()
Retired Lives:	Covered	(X)	Not Covered	()
Cobra Lives:	Covered	(X)	Not Covered	()

Newborn children of an employee who has previously enrolled and continues to cover eligible dependents under the Employee Benefit Plan will be eligible under this Policy on the date of the child's birth. Employees who have not previously enrolled for dependent coverage will be eligible for coverage for a newborn child in accordance with the provisions within the Employee Benefit Plan.

A. AGGREGATE EXCESS RISK INSURANCE

1. Company Limit of Liability

- N/A** of paid Aggregate Losses which are in excess of the Aggregate Attachment Point, subject to a maximum limit of **N/A**.
- Maximum amount per covered person chargeable to Aggregate Losses **N/A**.

2. Aggregate Attachment Point is the greater of:

- Single Attachment Factor: **N/A** per employee per month, Family Attachment Factor: **N/A** or
- Minimum Aggregate Attachment Point: **N/A**.

3. Covered Plan Benefits (Applicable only if an entry is specified herein.) **N/A**

() Medical () Prescription Drug

4. Loss Reduction for Insured Hospitals **N/A**

If the Participating Unit named herein is a licensed hospital, benefits payable under any applicable Employee Benefit Plan for expenses incurred as the result of services and charges provided by you shall be multiplied by **N/A** when determining paid Aggregate Losses.

5. Claims Basis - Benefit Period **N/A**

Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from **N/A** through **N/A**
and Paid from **N/A** through **N/A**

Plan Benefits Incurred prior to the Effective Date will be limited to: **N/A** for all covered persons combined.

SCHEDULE OF INSURANCE (Continued)

6. Additional Benefits **N/A**

Aggregate Accommodation Option: Yes () No ()
Aggregate Terminal Liability Option: Yes () No ()

B. SPECIFIC EXCESS RISK INSURANCE

1. Company Limit of Liability

- a. **100%** of Paid Specific Losses which are in excess of the Specific Deductible of **\$225,000** subject to a maximum limit per covered person of **Unlimited Annually , Unlimited Lifetime**.
- b. **\$225,000** Specific Deductible Amount (per person) after an Aggregating Specific Deductible of **\$250,000** has been satisfied for the entire group.

2. Covered Plan Benefits (Applicable only if an entry is specified herein.)
(**X**) Medical (**X**) Prescription Drug

3. Claims Basis - Benefit Period

Basis of Specific Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from 09/01/2012 through 08/31/2014.
and Paid from 09/01/2013 through 08/31/2014.

4. Loss Reduction for Insured Hospitals **N/A**

If the Policyholder named herein is a licensed hospital, benefits payable under any applicable Employee Benefit Plan for expenses incurred as the result of services and charges provided by the Participating Unit shall be multiplied by **N/A** when determining paid Specific Losses.

5. Additional Benefits:

Specific Advance Option: Yes (**X**) No ()
Specific Terminal Liability Option: Yes () No (**X**)

C. PREMIUM

1. Aggregate Excess Risk Premium

Estimated Deposit Premium: \$ N/A
Aggregate Premium Rate: \$ N/A
Estimated Annual Premium: \$ N/A

Aggregate Accommodation Option Premium: \$ N/A
Aggregate Terminal Liability Option Premium: \$ N/A

2. Specific Excess Risk Premium

Specific Premium Rate(s): \$ 22.06 Composite

Estimated Monthly Premium: \$ 59,250

Specific Advance Option Premium: **Included**
Specific Terminal Liability Option Premium: **N/A**

D. SPECIAL RISK LIMITATIONS:

Coverage under this Policy will be based on the current employee benefits as defined in the Employee Benefit Plan by reference or by attachment, except as noted below:

N/A

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GENERAL DEFINITIONS

"Actively at Work/Active" means that an employee is performing the ordinary duties of his or her job in the place and in the manner in which the job is normally performed and is not confined at home or to a hospital or other health care facility.

Dependents and COBRA Continuees and retirees will be considered "Active" if he or she is able to perform the normal activities of a person of like age and sex.

"COBRA Continuee" means any person who was insured under this Policy whose coverage is being continued in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

"Employee Benefit Plan" means the master plan document belonging to you which provides medical expense benefits and/or weekly accident and sickness benefits to your covered person(s), and dependents of such covered person(s), in effect on the Effective Date of this Policy, a copy of which is attached to and made a part of this Policy.

"Paid" means that funds are actually disbursed by the Policyholder/Participating Unit or the Policyholder's/Participating Unit's agent in payment of a claim. Payment of a claim is the unconditional and direct payment of a claim to a covered person or their health care provider.

"Usual, Customary and Reasonable Charges" is the amount which a provider routinely charges for goods and services provided, and is considered to be derived in conformity with the charge methodology of other similar or like providers within a geographic area, and is considered to represent a fair market value for the goods and services provided.

"us, we, our, the Company" mean Reliance Standard Life Insurance Company.

"you, yours" mean the Policyholder/Participating Unit and any subsidiaries, divisions or affiliates.

INSURING PROVISIONS

AGGREGATE EXCESS RISK INSURANCE: We will pay you a percentage of the amount by which the Aggregate Losses you have Paid under your Employee Benefit Plan exceed your Aggregate Attachment Point.

The percentage we will pay, and our Limit of Liability, are stated in your Schedule of Insurance. We will pay you as soon as reasonably possible after the end of your Policy Period, subject to satisfactory proof of loss.

SPECIFIC EXCESS RISK INSURANCE: We will pay you a percentage of the amount by which the Specific Losses you have Paid under your Employee Benefit Plan exceed the Specific Deductible Amount stated in your Schedule of Insurance.

The percentage we will pay and our Limit of Liability are also stated in your Schedule of Insurance. We will pay you as soon as reasonably possible after you have requested reimbursement, subject to satisfactory proof of loss.

"AGGREGATE LOSSES" means the total amount of money you have actually Paid during the Benefit Period as indicated in the Schedule of Insurance, or on behalf of, all covered persons under your Employee Benefit Plan. Aggregate Losses, however, cannot include any payments you made to, or on behalf of, a covered person:

1. for covered expenses which are reimbursable under the Specific Excess Risk Insurance provision; or
2. which were in excess of the maximum amount chargeable as stated in your Schedule of Insurance; or
3. which were not incurred within the Benefit Period as indicated in the Schedule of Insurance.

An expense will be deemed to be incurred by a covered person on the date that the service, treatment, or supply is provided.

Your payments must have been made in accordance with the provisions of your Employee Benefit Plan document currently filed with us and included as a part of this Policy. Payment shall be deemed to have been Paid by you when both of the following are satisfied:

1. You have directly tendered payment by mailing, or otherwise delivering, a check or draft in payment of a covered expense; and
2. the account upon which payment is drawn contains, and continues to contain, sufficient funds in order to honor such payment.

If the account upon which payment is drawn does not contain sufficient funds to cover all outstanding checks and drafts against the account, then we may consider, in our sole discretion, any particular checks or drafts as not having been Paid, but only to the extent of the total amount representing the difference between the funds in the account and the total of outstanding checks and drafts.

"SPECIFIC LOSSES" means the total amount of money you have actually Paid during the Benefit Period as indicated in the Schedule of Insurance, or on behalf of, any one covered person under your Employee Benefit Plan. Specific Losses, however, cannot include any payments you made to, or on behalf of, a covered person which were not incurred within the Benefit Period as indicated in the Schedule of Insurance.

An expense will be deemed to be incurred by a covered person on the date that the service, treatment, or supply is provided.

Your payments must have been made in accordance with the provisions of your Employee Benefit Plan document currently filed with us and included as a part of this Policy; and shall be deemed to have been Paid by you when both of the following are satisfied:

1. you have directly tendered payment by mailing, or otherwise delivering, a check or draft in payment of a covered expense; and
2. the account upon which payment is drawn contains, and continues to contain, sufficient funds in order to honor such payment.

If the account upon which payment is drawn does not contain sufficient funds to cover all outstanding checks and drafts against the account, then we may consider, in our sole discretion, any particular checks or drafts as not having been Paid, but only to the extent of the total amount representing the difference between the funds in the account and the total of outstanding checks and drafts.

INSURING PROVISIONS (continued)

AGGREGATE ATTACHMENT POINT

Your Aggregate Attachment Point will be determined at the end of your Policy Period. The Aggregate Attachment Point will be the greater of:

1. The Aggregate Attachment Point which is calculated as follows: At the beginning of each month during your Policy Period, the number of your employees, their dependents and other covered individuals, as agreed upon between you and us, who are covered under your Employee Benefit Plan will be multiplied by the corresponding Attachment Factor stated in your Schedule of Insurance; or
2. The Minimum Aggregate Attachment Point shown in your Schedule of Insurance. Your Minimum Attachment Point will be applicable regardless of how long your coverage remains in force.

EXCLUSIONS AND LIMITATIONS OF LIABILITY

1. Our liability under this Policy is limited to reimbursement of payments you have made to, or on behalf of, covered persons under your Employee Benefit Plan for covered expenses Paid under your Employee Benefit Plan. We are not liable for punitive, exemplary, or consequential damages, and you must hold us harmless from damages of any kind which are not caused by our own acts or omissions. You will indemnify us for all expenses, including attorney fees incurred in defending claims or legal actions brought against us by a person covered under your Employee Benefit Plan.
2. We will not be liable for expenses incurred by persons who became covered under your Employee Benefit Plan more than 31 days after their date of eligibility.
3. We will not be liable for expenses incurred by a covered person for the care or treatment of a sickness or injury which is caused by war, declared or undeclared, or any act of war.
4. We will not be liable for payments you have made to covered persons under any plan of benefits which has not been specifically identified as Covered Plan Benefits in your Schedule of Insurance.
5. We will not be liable to reimburse you for payments you have made to, or on behalf of, covered persons if your request for reimbursement is received by us more than 365 days following the expiration of the applicable Policy Period.
6. If the Participating Unit named in this Policy is a licensed hospital, our liability for expenses incurred by a covered person as a result of services and charges provided by you shall be as specified in items your Schedule of Insurance.
7. We will not reimburse expenses incurred by individuals who, on the latter of the Effective Date of their coverage under the Employee Benefit Plan or the Effective Date of this Policy are not Actively at Work. Benefits will not be paid until:
 - (a) the employee is Actively at Work for at least one (1) full day; or
 - (b) a dependent or COBRA Continuee or retiree is considered Active.
8. We will not be liable for expenses resulting from services which are billed in excess of the Usual, Customary and Reasonable Charges.
9. We will not be liable for expenses resulting from treatment, services or procedures which:
 - (a) are not accepted as standard medical treatment for the illness, disease or injury being treated by physicians normally practicing the specific medical specialty; or
 - (b) are the subject of scientific or medical research or study to determine the item's effectiveness and safety; or
 - (c) have not been granted, at the time services were rendered, any required approval by an appropriate federal or state governmental agency; or
 - (d) are performed subject to the covered person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.
10. We will not be liable for expenses related to an injury or sickness arising out of or in the course of any occupation for wage or profit or for which a covered person would be entitled to a benefit under any Workers' Compensation plan, except under the North Carolina Workers' Compensation Act to the extent indicated below, U.S. Longshoreman and Harbor Workers' Compensation plan or other occupational disease legislation or policy, whether or not such policy is actually in force.
11. We will not be liable for services or supplies for the treatment of an Occupational Injury or Sickness which are paid for under the North Carolina Workers' Compensation Act but only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
12. We will not be liable for expenses covered by amendments to the Employee Benefit Plan that were incurred prior to our written approval of such amendment.
13. We will not be liable for expenses that are covered under any Coordination of Benefits provision.

EXCLUSIONS AND LIMITATIONS OF LIABILITY (continued)

14. We will not be liable for expenses incurred by or on behalf of an employee or dependent of an employee of an affiliate or subsidiary company not included in the Request for Excess Loss Indemnity Coverage unless added to this Policy by endorsement.
15. We will not be liable for expenses incurred by or on behalf of a COBRA Continuee, retiree or retiree's dependent unless included in the Request for Excess Loss Indemnity Coverage or added to this Policy by endorsement.
16. We will not be liable for expenses arising from commission of a felony.
17. We will not be liable for expenses incurred by any COBRA Continuee whose COBRA continuation coverage was not offered in a timely manner.
18. We will not be liable for the cost of administration of claim payments including, but not limited to PPO Access Fees, or expense of litigation with individual claimants.
19. We will not be liable for your Third Party Administrator's (TPA) failure to provide timely payment to providers which results in the loss of any discounted fees for services or supplies. We will reimburse only for the discounted charge for services had timely payment been made by your TPA.
20. We will not be liable for expenses incurred by or on behalf of an employee or dependent of an employee that has reached the maximum under the current plan of benefits.
21. We will not be liable for expenses incurred by or on behalf of an employee or dependent of an employee who had a qualifying event but did not elect COBRA within the required time frame or whose COBRA benefit extension is exhausted.

PREMIUMS

AGGREGATE EXCESS RISK PREMIUM: The deposit premium shown in the Schedule of Insurance is payable by you on the Inception Date of the Policy Period.

SPECIFIC EXCESS RISK PREMIUM: Premiums are payable by you on a monthly basis.

The first premium is due on the Inception Date of your Policy Period, and subsequent premiums are due on the first day of each month thereafter.

OFFSET: We will be entitled to offset claim reimbursements to you against premiums due and unpaid by you.

RENEWAL

Your coverage may be renewed only if renewal is mutually agreeable to both you and us. If we refuse to renew, we must give you written notice 45 days prior to your expiration date. Your renewal is subject to our receipt and approval of a new Request For Excess Loss Indemnity Coverage. If approved, a new Schedule of Insurance will be issued to reflect any changes agreed upon by you and us.

GENERAL PROVISIONS

1. ACCESS TO RECORDS

We reserve the right to inspect and audit all records maintained by you and your Plan Supervisor with respect to your Employee Benefit Plan and with respect to this Policy. These records must be available to the Company or its designated Underwriting Manager for determination of plan benefits, proof of loss and proof of payment of plan benefits. Inspections and audits will be done during normal business hours.

2. AMENDMENT

This Policy may be amended from time to time by mutual consent of you and us. Any such amendment will be without prejudice to any claim arising prior to the date of change. No agent or other person, except the President, a Vice President or the Secretary of the Company, has authority to waive any conditions or restrictions of this Policy, to extend the time for paying a premium, or, to make or modify this Policy. No change in this Policy will be valid unless evidenced by an endorsement to it signed by you and by one of the aforesaid officers of the Company except those changes listed in the Group Specifications Changes provision.

3. ASSIGNMENT

You shall not assign any of your rights under this Policy without our prior written consent. Any assignment without prior written consent shall be void.

4. CHANGE OF YOUR EMPLOYEE BENEFIT PLAN

Your Employee Benefit Plan cannot be changed by you while you are covered under this Policy without our written consent.

Should you elect to change your Employee Benefit Plan, we reserve the right to change the Specific Excess premium rates and/or the Aggregate Attachment Factor, to reflect the effect of such changes.

5. CLERICAL ERROR

Clerical error, whether by you or us, in keeping any records pertaining to this coverage, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

6. ENTIRE CONTRACT

This Policy as issued to you, together with your application, entitled Request for Excess Loss Indemnity Coverage, the Participating Agreement, any amendments, and a copy of your Employee Benefit Plan, constitute the entire contract. We have relied upon the underwriting information provided by you or your agent in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would affect the rates, deductibles, terms or conditions of coverage, we will have the right to revise such rates, deductibles, terms or conditions as of the Effective Date of this Policy.

7. GRACE PERIOD

If any premium is not paid in full on or prior to its premium due date, a grace period of 31 days following the premium due date shall be granted for the payment of that premium. Your coverage will continue in full force and effect during the grace period. You will be liable to the Company for all premiums remaining unpaid on the date of termination of your coverage, including premium for the days of the grace period during which your coverage remained in force.

GENERAL PROVISIONS (continued)

8. INSOLVENCY

The insolvency, bankruptcy, financial impairment, receivership, or dissolution of the Participating Unit or your Plan Supervisor shall not impose upon us any liability other than the liability defined in this Policy. Your insolvency shall not make us liable to your creditors, including any covered person.

9 MISREPRESENTATION

In effecting this Policy, we shall be entitled to rely upon information provided by you or on your behalf. If that information proves not to have been correct as submitted, we have the right to rescind the coverage provided to you under this Policy as of its Effective Date or as of its last annual renewal date, if later. In lieu of rescission, we have the right to adjust the Specific Deductible Amount, the premium rates, the Aggregate Attachment Factor, and the Minimum Aggregate Attachment Point to those levels that we would have established if we had been initially provided with the correct information.

10. PAYMENT OF PREMIUMS

All premiums must be remitted to us at our Administrative Office. Except as otherwise provided under the provision entitled Grace Period, your coverage under this Policy will automatically terminate if any premium is not paid when due.

11. POLICY PERIOD: DURATION

Your Policy Period will begin on the Inception Date shown in your Schedule of Insurance. It will end, and all coverage provided by the Policy with respect to you will cease, on the earliest of the following dates:

1. the Expiration Date shown in your Schedule of Insurance;
2. the end of the Grace Period if any premium remains unpaid;
3. the date your Employee Benefit Plan terminates, or the date it changes, except as provided in the Change of Your Employee Plan provision;
4. the first day of any month specified by you following 30 days prior written notice to us;
5. the date you withdraw from the trust; or
6. the date the Plan Supervisor named in your Schedule of Insurance is changed, except as provided in the Plan Supervisor provision.
7. The date you do not pay claims or make available funds to pay claims as required by this Policy.

12. PLAN SUPERVISOR

You have appointed the Plan Supervisor named in the Schedule of Insurance to perform administrative services for your Employee Benefit Plan, including the payment of claims.

The Plan Supervisor is your agent and is not the agent of the Policyholder or Company. Neither the Policyholder or we are liable for any acts or omissions of the Plan Supervisor. Any requests or notices we send to the Plan Supervisor will be deemed as a request or notice sent to you.

You will enter into a written agreement with the Plan Supervisor. A copy of the written agreement will be furnished to us prior to the Inception Date of your Policy Period, or as soon as reasonably possible thereafter. The agreement will require your Plan Supervisor to fulfill the following duties and responsibilities:

- a. Administration and adjustment of all claims under the Employee Benefit Plan and verification of their validity, accuracy and computation; and
- b. Maintenance of accurate records of all claims payments; and
- c. Proper handling of and accounting for monies transmitted to and from you and us; and
- d. Payment of all claims within 31 days from the date satisfactory proof of loss has been established; and
- e. Submission to us within 15 days after the close of each Policy month, on a form supplied by us, a report containing all of the following information:
 1. the total number of covered persons for the month reported; and
 2. a statement of paid claims for the month reported.
- f. Satisfactory reporting and provision of proof requirements reasonably imposed by us.

The Plan Supervisor named in the Schedule of Insurance may not be changed unless prior written consent is obtained from us.

GENERAL PROVISIONS (continued)

13. SEVERABILITY

Any provision deemed void, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public policy, shall not render any of the remaining provisions of this Policy invalid.

14. TAXES

You shall hold us harmless from any state premium taxes which may be assessed against us with respect to benefits paid under your Employee Benefit Plan or this Policy, and shall reimburse us for such taxes, if any.

15. WORKERS' COMPENSATION INSURANCE

Coverage provided under this Policy applies only to covered expenses under your Employee Benefit Plan for non-occupational accidents and illnesses or those services or supplies for the treatment of an Occupational Injury or Sickness which have not been approved via a settlement agreement by the North Carolina Industrial Commission under the North Carolina Workers' Compensation Act. It is not the intent of this Policy to provide benefits for covered expenses provided by your Employee Benefit Plan in lieu of Workers' Compensation Insurance.

16. GROUP SPECIFICATIONS CHANGES

The Company reserves the right to revise rates, deductibles, terms or conditions of the Contract on any of the following dates:

1. When you add or delete a subsidiary or affiliate; or
2. When there is a change in the geographical area in which you are located; or
3. When there is a change in the nature of business in which you are engaged; or
4. When there is an increase or decrease in the number of covered persons which exceeds 10% in any one month or 20% over any period of three (3) consecutive months

CLAIMS PROVISIONS

NOTICE OF CLAIM

You are required, either directly, or through your Plan Supervisor, to provide immediate written notice to us when Specific Losses reach or are reasonably expected to exceed 50% of the specific deductible amount.

When Specific Losses exceed the specified deductible amount, proof of loss must be immediately submitted to us. Such proof will be provided on a form supplied by us, and shall include that information reasonably required to establish satisfactory proof of loss. Such information shall include, but is not limited to:

1. A completed proof of loss form;
2. Proof of the covered person's eligibility under the Employee Benefit Plan;
3. Proof of payment under your Employee Benefit Plan for those covered expenses being applied towards the satisfaction of the Specific Deductible Amount and for which reimbursement is being requested; and
4. Copies of all medical reports pertaining to this request for reimbursement.

WARRANTY

Upon presentation of proof of loss to us, you warrant that all monies necessary to pay for services and supplies have been Paid to the respective providers of medical services or supplies to which the claim for reimbursement relates.

LEGAL ACTION

No action at law or in equity will be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of five (5) years after the time written proof of loss is required to be furnished.

If any time limitation in this Policy with respect to bringing an action at law or in equity to recover on this Policy is less than that permitted by the law of the jurisdiction of issue, that limitation is hereby extended to agree with the minimum period permitted by that law.

PAYMENT OF CLAIM

We will pay all benefits as they become payable under this Policy to you. All expenses as they become payable under the Employee Benefit Plan shall be Paid by you. We shall pay the claim within a reasonable time after receiving fully executed written proof of loss and the documentation reasonably necessary to evaluate the eligibility and extent of the claim.

ARBITRATION

Any dispute or claim arising out of or relating to this Policy and our determination of claims payable thereunder, shall be settled by arbitration in accordance with the rules of the American Arbitration Association, with the express stipulation that the arbitrator(s) shall strictly abide by the terms of this Policy and shall strictly apply rules of law which are applicable. All matters shall be decided by a panel of three (3) arbitrators. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. This provision shall survive the termination or expiration of this Policy. The parties may alter any of the terms of this provision only by express written agreement, although such alteration may be before or after any rights or obligations arise under this provision.

This provision does not prohibit you from seeking a decision from a jury trial. You should be aware and understand that you may be giving up certain rights to have your dispute settled in and by a court of law, unless the law in your state provides for judicial review of arbitration proceedings.

SPECIMEN

RELIANCE STANDARD Life Insurance Company

Home Office: Chicago, Illinois • Administrative Office: Philadelphia, Pennsylvania

REQUEST FOR EXCESS LOSS INDEMNITY COVERAGE

Proposal Date: **June 7, 2013**

Group Policy Number: **SLM540087**

GENERAL INFORMATION

1. Full Legal Name of Policyholder/Participating Unit: **City of Durham**
Principal Address: **101 City Hall Plaza, Durham, NC 27701**
2. Nature of Business: **General Government**
3. Full Legal Name of Appointed Plan Supervisor **BC/BS of North Carolina**
4. If Employee Benefit Plan of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal names and addresses of such companies and the nature of their business. **N/A**
5. Disabled Lives: Covered (**X**) Not Covered ()
Retired Lives: Covered (**X**) Not Covered ()
Cobra Lives: Covered (**X**) Not Covered ()
6. Excess Loss Indemnity Policy Provisions
 - A. Aggregate Excess Risk Insurance
 1. Company Limit of Liability: **N/A** of paid Aggregate Losses which are in excess of the Aggregate Attachment Point, subject to an Aggregate Limit of Liability of **N/A**.

In addition, the Maximum amount chargeable per covered person to Aggregate Losses is subject to a maximum limit of **N/A**.
 2. Minimum Aggregate Attachment Point of **N/A**
 3. Additional Benefits: **N/A**
Aggregate Terminal Liability Option: Yes () No ()

(Continued)

7. Premiums:

Estimated Deposit Premium: \$ N/A
Aggregate Premium Rate: \$ N/A

Aggregate Terminal Liability Option Premium: **N/A**

8. Claims Basis - Benefit Period

Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from N/A through N/A
and Paid from N/A through N/A

Plan Benefits Incurred prior to the Effective Date will be limited to:

\$ N/A for all covered persons combined.

9. Covered Plan Benefits (Applicable only if an entry is specified herein.)

(X) Medical (X) Prescription Drug

10. Loss Reduction For Insured Hospitals – **N/A**

If the Policyholder named herein is a licensed hospital, benefits payable under any applicable Employee Benefit Plan for expenses incurred as the result of services and charges provided by the Participating Unit shall be multiplied by N/A % when determining paid Aggregate Losses.

B. Specific Excess Risk Insurance

1. Company Limit of Liability:

a. **100%** of paid Specific Losses which are in excess of a specific deductible of **\$225,000**, subject to a Maximum Limit of Liability per covered person of **Unlimited Annually, Unlimited Lifetime**.

b. **\$225,000** Specific Deductible Amount (per person) after an aggregate corridor of **\$250,000** has been satisfied for the entire group.

2. Additional Benefits:

Specific Advance Option: **Included**

Specific Terminal Liability Option: Yes () No (X)

3. Premiums: Specific Premium Rate(s): Composite: \$ 22.06

Specific Terminal Liability Option Premium: **N/A**

4. Claims Basis - Benefit Period

Basis of Specific Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from 09/01/2012 through 08/31/2014
and Paid from 09/01/2013 through 08/31/2014

(Continued)

5. Covered Plan Benefits (Applicable only if an entry is specified herein.)

(X) Medical (X) Prescription Drug

6. Loss Reduction For Insured Hospitals – **N/A**

If the Policyholder named herein is a licensed hospital, benefits payable under any applicable Employee Benefit Plan for expenses incurred as the result of services and charges provided by the Participating Unit shall be multiplied by N/A % when determining paid Specific Losses.

7. Estimated amount as an advance Payment on the premium for insurance applied for is **\$ 59,250**.

8. Inception Date: **September 1, 2013** Expiration Date: **August 31, 2013**

9. As a condition of acceptance, the Policyholder/Participating Unit has conducted a thorough review of experience developed under its Employee Benefit Plan, and as a result thereof, represents that there are no covered persons with known disabilities, or other known conditions expected to result in paid claims in excess of the Specific Deductible Amount during the Benefit Period, other than those previously disclosed as the basis for proposed coverage.

C. Special Risk Limitations:

Coverage under this Policy will be based on the current employee benefits as defined in the Employee Benefit Plan by reference or by attachment, except as noted below:

N/A

Reliance Standard Life Insurance Company accepts this request for the above coverage. Coverage is in effect for the period shown in item 7. Renewal of this request for a further period must be submitted on a new form.

ACCEPTED BY:

RELIANCE STANDARD LIFE INSURANCE COMPANY

By: Nicholas C. Milligan
Signature

Printed Name: Nicholas C. Milligan

Title: Stop Loss Specialist

Date: July 9, 2013

ACCEPTED BY:

City of Durham

By: _____
Signature

Printed Name: _____

Title: _____

Date: _____

SPECIMEN

RELIANCE STANDARD LIFE INSURANCE COMPANY
Administrative Office: Philadelphia, Pennsylvania

Waiver of Actively-at-Work Requirement

Reliance Standard Life Insurance Company has issued this Endorsement as a part of the Policy to which it is attached.

The Exclusions and Limitations of Liability section is hereby amended to waive the Actively at Work requirement.

The waiving of this requirement is based on the employer and the claims administrator performing thorough due diligence in completing the disclosure. Any material misrepresentation which alters the risk, whether intentional or unintentional, may result in denial of claims, revised terms and conditions, and/or the exclusion of participants in the plan(s) under the Policy.

Disclosure is not required on persons whose coverage becomes effective under the Plan after the Effective Date of this Policy, except with respect to employees (and their dependents) of an affiliated or subsidiary company that is not listed in the Request for Excess Loss Indemnity Coverage or added to the Policy by Endorsement.

ALL OTHER TERMS AND PROVISIONS OF THE POLICY TO WHICH THIS ENDORSEMENT IS ATTACHED REMAIN THE SAME.

Signed for RELIANCE STANDARD LIFE INSURANCE COMPANY



Secretary

Endorsement Number: 1

Effective Date: September 1, 2013

Excess Loss Policy Number: SLM540087

Participating Unit's Name: City of Durham

Signature of Participating Unit's Authorized Representative: _____

Authorized Representative's Title: _____

Date Signed: _____

Cost Summary

Prepared for City Of Durham
Date: June 7, 2013

Proposal Expiration Date: September 15, 2013

PROPOSAL QUALIFICATIONS AND CONTINGENCIES

- o The coverage contains certain Exclusions and Limitations. Please contact your sales representative for a copy of the Excess Loss Indemnity Group Policy.
- o This proposal is based on the information submitted. If it is determined that the information presented for the purposes of underwriting evaluation is found to be inaccurate and/or incomplete, underwriters reserve the right to modify and re-evaluate terms.
- o Underwriting reserves the right to modify coverage terms when the participation varies by more than 10% of the quoted or prior enrollment; when a new division is added or deleted from coverage; or when plan and/or network changes occur.
- o Proposed terms warrant that managed care features such as Pre-certification, Utilization Review and Large Case Management are mandatory.
- o Actively At Work/Active at Life requirements will apply, subject to receipt and evaluation of full and complete disclosure details per the attached sheet.
- o The Disclosure Statement must be completed in its entirety and signed by all appropriate representatives of the Plan.
- o This proposal is valid only if presented by a licensed insurance agent or broker who is appointed by Reliance Standard. It is valid until the date shown, unless we replace or withdraw it.
- o This proposal is contingent upon review of LCM notes or detailed information for any claim @ 50% or potential to reach 50% of the deductible level offered and should include the full diagnosis, paid to date amount, current treatments, dates of service, date first diagnosed, prognosis, if known, and an estimate of future costs.
- o Specific Advance is included.
- o This proposal assumes duplication of the current plan design and continuing utilization of the existing BOBS of NC PPO network.
- o Other than state premium tax, proposed rates are exclusive of any additional state assessments which may apply.
- o Expenses for taxes, fees and surcharges that may be imposed on the Benefit Plan by Federal, State or local governments are not covered as eligible expenses for reimbursement consideration under the Stop Loss Coverage.
- o This proposal assumes that Retirees age 65 or older (if a covered class) are Medicare Primary. Confirmation of Retiree eligibility rules will be required prior to binding of coverage.
- o A signed plan document must be received and accepted by the underwriter within 90 days of the effective date or the stop loss policy is not valid.
- o Quote is subject to receipt and evaluation of updated paid claims, pending claims, denied claims, held and/or unfunded claim details, precertification information, updated shock loss history and enrollment information through 6/30/2013, or the date disclosure is signed, whichever comes later.
- o Claimant identifier information will be required at time of binding of coverage in order to give proper disclosure credit.
- o The Aggregating Specific Deductible represents the accumulation of all losses eligible for specific excess coverage above the specific level for one or more claimants. No reimbursement for specific claims will be made until this corridor has been satisfied. This corridor is not eligible for accumulation towards the aggregate coverage.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TORIO MARINE GROUP

Cost Summary

Prepared for City Of Durham

Date: July 8, 2013

Proposal Expiration Date: September 15, 2013

o If the stop loss contract has the aggregating specific option, the maximum payment under the specific excess policy is the maximum policy amount less any portion of the aggregating specific corridor.

o Proposal is based on a minimum of 75% participation.

o Any individual identified with a termination date (non Cobra beneficiary) prior to the effective date will be excluded from coverage unless we are notified of a change of status prior to the binding of coverage.

o In order to finalize our 24/12 offer, we require Pended Claims, Pre-Cert and lag reports.

o IF THE STOP LOSS TERMS ARE BASED ON AN UNLIMITED MAXIMUM, a response to the following questions is REQUIRED: In the past 5 years, has any employee or dependent: 1. Reached the plan's lifetime or annual Maximum yes OR no 2. If #1 above is yes, then do they meet the plan definitions eligibility yes OR no 3. If you checked yes to #1 and #2 above, full disclosure is REQUIRED for each individual on the accompanying disclosure form. Coverage for each individual listed will be excluded from the policy unless determined that the individual will NOT be a known ongoing Specific Stop Loss claimant.

o For any claimant listed with diagnosis of ESRD or Renal/Kidney disease, please indicate if claimant is on dialysis, the date claimant started on dialysis, monthly cost of dialysis and the date Medicare will become primary payor.

o For any claimant on a transplant list or being evaluated for a transplant, please provide network and facility selected and case rate for transplantation if already negotiated.

Initial the selected proposal option:

Specific

Aggregate

Option 1
\$22.06
N/A

The Premium and Aggregate Deductible are based on the data submitted. Any inaccurate or incomplete data submitted may require changes at final underwriting. We will not be bound by any typographical errors or omissions contained herein.

Date:

JULY 8, 2013

By:

[Signature] IBA, INC.
Agent of Record or Administrator

Group Stop Loss coverage is provided by Reliance Standard under Policy Form #LRS-9101, et al. Benefit provisions may vary by state.

This proposal expires if applications are not requested before the valid through date.

RELiance STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

RELIANCE STANDARD LIFE INSURANCE COMPANY Disclosure Form

Claimant	DOB	Status	Diagnosis	Prognosis	Most Recent DOS	Claims Paid in Last 12 months	Pended, Denied, and Pre- Authorized Claims During The Past 12 Months
		<input type="checkbox"/> Employee <input type="checkbox"/> Dependent <input type="checkbox"/> COBRA					
		<input type="checkbox"/> Employee <input type="checkbox"/> Dependent <input type="checkbox"/> COBRA					
		<input type="checkbox"/> Employee <input type="checkbox"/> Dependent <input type="checkbox"/> COBRA	SEE	ATTACHED			
		<input type="checkbox"/> Employee <input type="checkbox"/> Dependent <input type="checkbox"/> COBRA					
		<input type="checkbox"/> Employee <input type="checkbox"/> Dependent <input type="checkbox"/> COBRA					
		<input type="checkbox"/> Employee <input type="checkbox"/> Dependent <input type="checkbox"/> COBRA					

The Plan Sponsor named below represents that the above list accurately discloses all potentially catastrophic claimants in accordance with the instructions attached to this form and that it is the result of a diligent search in accordance with those instructions. Such disclosure includes, but is not limited to, those individuals currently eligible under the plan that were formerly ineligible due to meeting their lifetime maximum in the past. The Plan Sponsor recognizes that if the Plan Sponsor fails to disclose any Participant known to fall into one of the categories set forth in the instructions attached to this form, either intentionally or because a thorough review of all records was not conducted, then the coverage proposed may be re-evaluated and Participants not disclosed may be individually underwritten retroactively to the effective date. We reserve the right to terminate or limit the Participant's participation in the Policy, change or modify the Premium Rates or Specific Deductible Amount(s), or adjust the terms of the Specific or Aggregate coverage quoted.

Plan Sponsor: CITY OF DURHAM, NC.
 Signature: _____
 Printed Name: _____
 Title: _____
 Date: _____

Agent/Broker: THE CASARETTI, ISA
 Signature: [Signature]
 Printed Name: JOHN CASARETTI
 Title: PRESIDENT, ISA, INC
 Date: JULY 8, 2013



**BlueCross BlueShield
of North Carolina**

An Independent Licensee of the
Blue Cross and Blue Shield Association

ASO Financial Operations

CITY OF DURHAM

**Specific Stop-Loss Report
Reporting Period: 9/1/2012 Through 5/31/2013**

Group Number: 069114
Specific Period: 9/12 Through 5/13
Specific Stop Loss Limit: 225,000

<u>GROUPID</u>	<u>DEPT ID</u>	<u>MEMBER NUMBER</u>	<u>MEMBER NAME</u>	<u>Total-Pooled</u>	
				<u>Total Claims Paid</u>	<u>Current</u> <u>Cumulative</u>
069114	069114AC20			290,258.92	65,258.92 \$65,258.92
	Highest Payment	\$260,712.74	Diagnosis Code	493.91	
069114	069114AC12			280,143.14	32,358.15 \$55,143.14
	Highest Payment	\$29,475.00	Diagnosis Code	416.0	
069114	069114AC10			321,512.11	5,181.23 \$96,512.11
	Highest Payment	\$47,495.26	Diagnosis Code	V58.11	
069114	069114RC12			281,550.81	56,550.81 \$56,550.81
	Highest Payment	\$21,445.20	Diagnosis Code	V58.11	
069114	069114AP10			233,613.83	8,613.83 \$8,613.83
	Highest Payment	\$29,769.30	Diagnosis Code	555.9	
069114	069114AB20			287,059.06	15,815.38 \$62,059.05
	Highest Payment	\$115,000.00	Diagnosis Code	203.00	
Total Specific Stop Loss Credits:				183,778.32	344,137.86
Total Cumulative Stop Loss Credits:					344,137.86
Total Cumulative Stop Loss Limit:					250,000.00
Current Period Credits:					94,137.86
Contract to Date Credits:					94,137.86



**BlueCross BlueShield
of North Carolina**


An Independent Licensee of the
Blue Cross and Blue Shield Association

ASO Financial Operations

CITY OF DURHAM

Specific Stop-Loss Report @ 50.00%
Reporting Period: 9/1/2012 Through 5/31/2013

Group Number: 069114
Specific Period: 9/12 Through 5/13
Dollar Limit: 112,500

GROUP ID	DEPT ID	MEMBER NUMBER	MEMBER NAME	Total Claims Paid	Total Pooled Current	Cumulative
<div><div><div><div>BlueCross BlueShield of North Carolina</div><div>An Independent Licensee of the Blue Cross and Blue Shield Association</div><div>ASO Financial Operations</div></div></div><div><div>CITY OF DURHAM</div><div>Specific Stop-Loss Report @ 50.00% Reporting Period: 9/1/2012 Through 5/31/2013</div></div></div>						
Group Number: 069114 Specific Period: 9/12 Through 5/13 Dollar Limit: 112,500						
GROUP ID	DEPT ID	MEMBER NUMBER	MEMBER NAME	Total Claims Paid		Cumulative
069114	069114RP12			153,087.89		40,587.89
Highest Payment		\$10,183.30	Diagnosis Code			
069114	069114AC12			115,930.80		3,430.80
Highest Payment		\$79,460.48	Diagnosis Code			
069114	069114AC20			290,258.92		177,758.92
Highest Payment		\$260,712.74	Diagnosis Code			
069114	069114AC12			280,143.14		167,643.14
Highest Payment		\$29,475.00	Diagnosis Code			
069114	069114RP			208,488.95		95,988.95
Highest Payment		\$9,770.32	Diagnosis Code			
069114	069114AC10			321,512.11		209,012.11
Highest Payment		\$47,495.26	Diagnosis Code			
069114	069114RC12			281,550.81		169,050.81
Highest Payment		\$21,445.20	Diagnosis Code			
069114	069114RB12			132,407.77		19,907.77
Highest Payment		\$15,387.43	Diagnosis Code			
069114	069114RC12			130,348.57		17,848.57
Highest Payment		\$1,359.56	Diagnosis Code			
Highest Payment						

<u>GROUPID</u>	<u>DEPT ID</u>	<u>MEMBER NUMBER</u>	<u>MEMBER NAME</u>	<u>Total Claims Paid</u>	<u>Total Pooled</u>	
				<u>Current</u>	<u>Cumulative</u>	
069114	069114AP10			233,613.83	121,113.83	
	Highest Payment	\$29,769.30	Diagnosis Code 555.9			
069114	069114AC20			149,998.07	37,498.07	
	Highest Payment	\$17,581.68	Diagnosis Code			
069114	069114AB20			287,059.05	174,559.05	
	Highest Payment	\$115,000.00	Diagnosis Code 203.00			
069114	069114RC12			224,113.72	111,613.72	
	Highest Payment	\$14,279.04	Diagnosis Code 174.8			
069114	069114AP22			127,487.70	14,987.70	
	Highest Payment	\$2,966.36	Diagnosis Code 585.6			
069114	069114AP22			121,913.27	9,413.27	
	Highest Payment	\$39,890.54	Diagnosis Code 196.2			
Total CTD Stop Loss Credits @ 50.00% :					1,370,414.60	
Total Cumulative Stop Loss Credits:					1,370,414.60	
Total Cumulative Stop Loss Limit:					250,000.00	
Contract to Date Credits @ 50.00 :					1,120,414.60	

Total Claims Paid Amounts exclude Dental and Care Management Fees

ICD-9 Codes for Disclosure Notification

Please list all Plan Participants who have been diagnosed with or treated for any of the codes listed under the following categories during the current Benefit Period:

001-139 Infections and Parasitic Diseases

038-038.9 Septicemia
042 AIDS / HIV
070-070.9 Viral Hepatitis

140-239 Neoplasms

140-149.9 Malignant Neoplasm of Lip, Major Salivary Glands, Gun, Mouth, Oropharynx, Nasopharynx, and/or Hypopharynx
150-150.9 Malignant Neoplasm of Esophagus
151-151.9 Malignant Neoplasm of Stomach
153-153.9 Malignant Neoplasm of Colon
154-154.8 Malignant Neoplasm of Rectum
155-155.2 Malignant Neoplasm of Liver
157-157.9 Malignant Neoplasm of Pancreas
161-161.9 Malignant Neoplasm of Larynx
162-162.9 Malignant Neoplasm of Lung
170-170.9 Malignant Neoplasm of Bone
174-174.9 Malignant Neoplasm of Female Breast
179-182.8 Malignant Neoplasm of Uterus or Cervix
183-183.9 Malignant Neoplasm of Ovary
185 Malignant Neoplasm of Prostate
186-186.9 Malignant Neoplasm of Testis
188-189.9 Malignant Neoplasm of Bladder, Kidney, Urinary
191-191.9 Malignant Neoplasm of Brain
192-192.9 Malignant Neoplasm of Nervous System
194-194.9 Malignant Neoplasm of Endocrine Glands
195-195.8 Malignant Neoplasm of Other Ill-Defined Sites
196-196.9 Secondary Malignant Neo. Lymph Nodes
197-197.8 Secondary Malignant Neo. Respiratory and Digestive Systems
198-198.89 Secondary Malignant Neo. Other Specified Sites
200-208.9 Lymphoma and/or Leukemia
235 Neoplasm Uncertain Behavior
239.2 Neoplasm Unspecified Nature - Bone, Skin

240-279 Endocrine, Nutritional, Metabolic, Immunity

250-250.9 Diabetes
277.0 Cystic Fibrosis
278.0 Obesity/Hypertalimint
279 Disorders Involving the Immune Mechanism

280-289 Diseases of the Blood and Blood-Forming Organs

282.6 Sickle-Cell Anemia
284.9 Aplastic Anemia NOS
286-286.9 Coagulation Defects and/or Hemophilia

320-389 Diseases of the Nervous System and Sense Organs

330 Cerebral Degenerations
344.0-344.09 Quadriplegia and Quadriparesis
331.0-331.9 Reye's Syndrome
344.1 Paraplegia
348.0-348.9 Encephalopathy
357, 358 Neuropathy / Myasthenia Gravis

390-459 Diseases of the Circulatory System

410-410.9 Acute Myocardial Infarction
411-411.89 Acute and Subacute Ischemic Heart Disease
414-414.05 Coronary Atherosclerosis (ASHD)
415-415.19 Acute Pulmonary Heart Disease
416-416.9 Chronic Pulmonary Heart Disease
417.1 Aneurysm of Pulmonary Artery
421-421.9 Acute and Subacute Endocarditis
424-424.9 Valve Disorders
425-425.9 Cardiomyopathy
426-426.9 Conduction Disorders
427-427.9 Cardiac Dysrhythmias
428-428.9 Heart Failure
430, 431 Subarachnoid / Intracerebral Hemorrhage
434.9 Occlusion of Cerebral Arteries
436 Acute Cerebrovascular Accident (CVA)
440-441.9 Atherosclerosis / Aortic Aneurysm

460-519 Diseases of the Respiratory System

480-486 Pneumonia
490-496 Chronic Obstructive Pulmonary Disease (COPD), etc.
515 Postinflammatory Pulmonary Fibrosis
518-518.89 Pulmonary Collapse and/or Respiratory Failure

520-579 Diseases of the Digestive System

555-555.9 Regional Enteritis (Crohn's Disease)
560.0-560.9 Intestinal Obstruction
562.1 Diverticulitis of Colon
567-567.9 Peritonitis
569.0-569.9 Other Disorders of Intestine
570-571.9 Liver Diseases and Cirrhosis
572.8 Other Sequela of Chronic Liver Disease
573-573.9 Other Liver Disorders
577-577.9 Pancreas Diseases
578-578.9 Gastrointestinal Hemorrhage

580-629 Diseases of the Genitourinary System

584-584.9 Acute Renal Failure
585 Chronic Renal Failure
586 Renal Failure, Unspecified
588 Disorders resulting from impaired renal function
592 Calculus of Kidney & Ureter

630-677 Complications of Pregnancy, Childbirth

641.1 Placenta Previa
642.5-642.7 Eclampsia, pre-eclampsia
644.0-644.2 Premature Labor
648.0 Gestational Diabetes
651 Multiple Gestation
654.5 Cervical Incompetence

710-739 Diseases of the Musculoskeletal System and Connective Tissue

715.0-715.9 Osteoarthritis
721.3 Lumbosacral Spondylosis
722.0-722.9 Intervertebral Disc Disorders
730-730.9 Osteomyelitis and/or Periostitis
737.3 Kyphoscoliosis and scoliosis

740-759 Congenital Anomalies

747.2 Aortic Atresia / Stenosis
751.6 Biliary Atresia
759-759.9 Other and Unspecified Congenital Anomalies

760-779 Conditions Originating in the Perinatal Period

765-765.1 Prematurity
769 Respiratory Distress Syndrome
770.0-770.9 Other Respiratory Conditions of Newborn

780-799 Symptoms, Signs, and Ill-Defined Conditions

785-785.9 Symptoms Involving Cardiovascular System
786.5-786.59 Chest Pain

800-999 Injury and Poisoning

800-804.9 Fracture of Skull
805-805.9 Fracture of Vertebral Column
806-806.9 Fracture of Vertebral Column with Spinal Cord Injury
828-828.1 Multiple Fractures
853-854.1 Intracranial Injury
869-869.1 Internal Injury
887-887.7 Traumatic Amputation of Arm and Hand
897-897.7 Traumatic Amputation of Leg
949-949.5 Burns
952-952.9 Spinal Cord Injury
996-997.0 Complications peculiar to certain specified conditions

Additional Codes

V23 Supervision of High Risk Pregnancy
V42 - V58.9 Transplants, etc